Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
ACIG Insurance Co

MFDR Tracking Number
M4-14-3173-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $139.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent respectfully contends that requestor should bill with the appropriately designated coding per current CMS policy so that correct fee schedule allowance can be made."

Response Submitted by: Carl Warren & Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2014	Physician Services	$139.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B15 – Procedure/Service is not paid separately
   - 25 – Separate E&M Service, Same Physician
   - RB – Not paid under OPPS no sep payment/packaged svc

Issues

1. Did the requestor support services billed correctly?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed services as, RB – "Not paid under OPPS no sep payment/packaged svc." 28 Texas Labor Code §134.403(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…" Review of www.cms.hhs.gov , Change Request 8572 finds the following; "Effective January 1, 2014, CMS will recognize HCPCS cod G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits. CPT codes 99201-99205 and 99211-99215 will no longer be recognized for payment under the OPPS." The submitted claim contained CPT code 99213 as an Outpatient Hospital Claim. The carrier's denial is supported.
2. The Division finds the requirements of 28 Texas Labor Code §134.403(d) were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.